Minutes
DPHHS Rates Commission
June 28, 2006
Capitol Room 152
Helena, Montana

Attendees: Diana Tavary – Vice Chair, Mary Jean Golden, Frieda Houser, Barb Varnum, Representative Christine Kaufmann – Chair, Representative Penny Morgan, Senator Dan Weinberg, Senator John Cobb, Lois Steinbeck, Bob Anderson, Janet Whitmoyer, James Corrigan, Kathy Brophy, Bob Olsen, and Gail Briese-Zimmer

Absent Members: William Hershey

Guests: Sami Butler – Intermountain Children's Home, Kate Wilson – Cooperative Health Center, Denise Brunett – HRD, Mary Dalton – HRD, Jeff Harrison – OPCA, Duane Preshinger – OPCA, Mike Hanshew – Montana Health Solutions, Charlie Briggs – MACDS, Jami McCall – MCIPA, Dave Thorsen - CFSD

Welcome: Meeting started at 1:05 PM
Representative Christine Kaufmann – Chair:
Commission was welcomed and meeting began.

Approval of Minutes:
Commission Members:
There were not comments or concerns about the minutes. Kathy moved to approve the minutes. Diana seconded.

Physician Rates Access concerns:
Mary Dalton – Administrator DPHHS Health Resources Division:
There were two handouts given to everyone. Mary gave a brief overview of what the handouts showed. She stated that in 2004 Medicaid fees ranged from 41-58% of Blue Cross Blue Shield (BCBS) fees. Today they are at 51-71% of BCBS and New West because legislature gave a good raise the last session. She stated that in general preventative procedures are a little bit higher and obstetrics are always paid higher because Medicaid pays for over 40% of all births in Montana. She stated that they also watch their charge ratio. This is important because when Medicaid was established the goal was to pay 65.2% of charges. They now, in the physician's area, pay on average $.46 for every $1 charged.

She stated that there are some areas with access difficulties. Lack of access is as much related to towns as it is related to specialties and some is related to what your expectation is of what your access should be. Overall physicians are not anywhere close to being in the category of shortages as dentist are from a Medicaid access point. She stated that she is not aware of any studies that compare whether a physician is not accepting new Medicaid clients or any new clients.

Denise Brunett – DPHHS Health Resource Division:
She clarified that the current pay to charge ratio of 43% has gone up to 46% since the $5 million targeted increase from July 1 of last year and patients can enroll with PCP 75% of the time who they choose.

Questions and Comments:
It was asked if it has been considered what percentage they would need to be at to where access would not be a problem.

Mary stated that 100% of charges would be the easiest way to say that there would not be an access problem. Even at that, there was a state that was paying over a 100% to a certain physician group and they still did have some access problems. She stated that if you do not have enough physicians care in a town it will not matter what you pay everyone in town will have that same lack of access to a physician.

It was brought up that if Medicaid wanted to give certain selected doctors a bump above Medicare as long as you were lower on certain other procedures you would be ok.

Mary stated that for instance Medicaid pays more to anesthesiologist than Medicare. In RBRVS they have a policy adjuster for obstetrics because if they strictly applied the RBRVS rate of payment as they do with other specialties, they would have serious access problems. She stated that their core business is women, children and the elderly which are primarily cared for by pediatricians, obstetricians, internal medicine, and family practitioners.

It was asked what role the commission could play to look at the whole area of physician rates that would be helpful.

Mary stated that it would be both helpful to see what we might want to pay as a percentage of Medicare and then set a target that you would like for Medicaid to pay. She stated that another area of concern that the council could look at is paying certain providers a higher rate. As an example, pediatricians as a group of providers have an abnormally high percentage of Medicaid clients in their practice. At one time pediatricians were way over 50% of their clientele were Medicaid. That is when you start worrying about how low you are paying. When you start looking at specialties, for some approximately 5% of their clients are Medicaid. What this commission might look at is that overall we would try and go for an aggregate percentage but give some flexibility or guidance as to how it should be applied.

A member asked how one state is paying 115.8% of Medicare and how do they do that.

Mary stated that she does not think that physicians are limited to an upper payment on Medicare. Hospitals and facilities are but doctors are not. It was thought that maybe as a general rule of thumb say more facility based care has an upper payment limit. The regulations that apply with Medicaid specifically limit with an upper limit are nursing homes and hospitals. Pharmacy has different regulations on what the upper limit is.

It was asked if when the 2006 estimates were done and the rates were raised if it made any difference or not.

Denise stated that they pay less than one tenth of their services off the by report percentage. When rate increases were done it took it from 43% to 47% in state fiscal year 2007.

It was stated that the Medicaid world according to Dalton has four major players. There are pharmacies which rise with cost and they pretty much take care of themselves. There are hospitals that take care of themselves now through utilization fees. Nursing facilities are a major player and they have a bed tax. There are also physicians that have a large number of Medicaid clients and are integral in the provision of referral to a number of other services. They do not have a mechanism currently to make sure that they are reimbursed in the same way that the other three are.

It was asked what is in the Executive budget as far as rate increase.

Bob Anderson stated that he was not sure that there was a rate increase in there right now. There is about 95 million that is targeted towards Medicaid for the present law items. It is really not a rate increase just a present law adjustment.

It was asked if there were geographic pockets in Montana that have access problems.

Mary stated that it tends to be more geographic. In specialties there aren't any that she is aware of.

It was asked how they compensate for the fact that it cost more to live in some towns then it does in others.

Mary stated that due to the large number of practices there really is no difference in payments for practices in different location. We currently only do this for cost based providers such as critical access providers and it would be a nightmare if we were to do it for physician practices because of the sheer number of providers. Where there is differentiation is whether they are hired by the hospital or if they are provider based.

It was asked if RBRVS is transferable to other kinds of systems that we are looking at.

Mary stated that it is and that there is already a similar kind in three different areas: DRG, APC, and RVD.

Presentation from the L&C Community Health Center:

Kate Wilson – Lewis and Clark CHC:

Kate gave an overview of the presentation that she handed out. She stated that there are approximately eleven Community Health Centers (CHCs) in Montana. In 2004 the CHCs provided 201,387 visits to 66,192 Montanans. She gave some statistics as to what their patients earned. She gave a brief overview of what CHCs provide. Some CHCs have their own pharmacies and some don't. Those that do not have a pharmacy give their patients access to what is called 340B prices that are a little better than VA prices. There is also something called Medication Assistance Program (MAP), which is a person hired

to help patients get their medications for free from the pharmaceutical companies if the patients qualify.

Kate stated that CHCs are reimbursed by Medicaid through the Prospective Payment System, which is a set rate for each center for all types of levels and visits. She went over a graph that shows how a CHC is funded. She stated that these vary based on location. CHC is a business and over half of the revenues come from patient or insurance payments.

Questions and Comments:

It was asked how the CHC determines what services it will provide.

Kate stated that new CHCs are required to provide mental health, dental and primary care. Older health centers have to make a business decision to provide that service. They are determined on volume.

A member requested that she give a break down on how the visits are calculated.

Kate stated that it may vary based on situations and the person.

It was asked how a CHC came about and if they were to meet some specific need.

Kate stated she believes the first one was in the 1960s. They kind of grew out of free clinics movement and they became funded by the federal government. They are also seen as economic development engines for communities. The mission is broader than just providing health care but also advocating for better economic conditions for our patients.

It was asked if there is an income cut off.

Kate stated that anyone can come to the clinic no matter what the income. They will bill the insurance like a private clinic would.

A member asked about the migrant program and how it operates.

Kate stated that it is based out of Billings and that they are mostly open seasonally when the migrant agricultural workers are in those areas. There is a mobile van for dental and permanent clinics.

It was stated with the immigration being on the forefront of the national political scene the department paying for health care for illegal aliens.

It was asked why the CHC is not being paid by RBRVS.

Mary Dalton stated that Medicaid pays as relative to other providers better because they don't have anyone to cost shift to.

The commission asked what they could do to be helpful in issues around rates as they relate to the CHC.

Kate said to save the PPS rate. Many other states support their CHCs but Montana does not and so Medicaid is the best source of income that they have to keep the doors open.

It was mentioned that there is one in Ashland and asked how it differs from the tribal clinics.

Kate stated that they can offer the sliding fee scale to everyone not just tribal members.

Why does Ashland have one?

They happened to get their application in at the right time when they were very easy to get approved. There are a couple of places that need them but cannot get one.

Review of Rates Grid:

Jeffrey Harrison – OPCA Financial Specialist Supervisor:

Jeff gave a brief overview of what the grids tell you. He stated that the only difference in the non-community based grid is the addition of some provider types. The community based is different is that they have added Chemical Dependency, the specific rates, funding sources, and more specific descriptions to the services.

Questions and Comments:

A member requested a clarification of the Approximate Number of Rates column and what the number means.

Jeff stated that there are that many codes in that type of claim.

When the grid is updated again it was asked that the range is put in where there is only one rate.

It was brought up that in the Mental Health Centers there is a funding source of TANF. It was asked if that was TANF block grant funds.

Mary stated that it is TANF maintenance of effort funds.

It was asked why there are no beds at the moderate level under therapeutic group homes.

Mary stated that moderate was gotten rid of.

It was stated that they would like to know more about how the mental health group home rates are calculated compared to foster group home rates.

It was asked, that under the DD page there is small, medium, and large homes, is that referring to the number of people that the number of people that that home will handle.

Jeff stated that it refers more to the size of the organization. Larger organizations are able to spread the overhead over a larger number of facilities and/or patients.

What are the 0, 3, and 6% geographic factors?

It is being paid based on where they are situated.

It was asked what the per visit unit under Chemical Dependency means.

That is the rate for one complete assessment. Those could take anywhere between two and four hours.

The differentiation between the regular and the frontier rate is that a geographic thing.

Jeff stated that it is. The frontier rates are higher in CD just to maintain access in those more remote areas.

How is it figured where those rates are paid?

It is anything that is not within the larger communities.

It was asked if a person wanted to find rates that were comparable in the home and community based services with senior and long term care are they listed.

They are not yet but this is still a work in progress.

Is SLTC the only group not reflected in this yet?

Jeff did not say for absolute sure but he thought that it was.

The commission asked what else they anticipate wanting to do with this.

Jeff stated that there are specific service groups that will be added other than that we would just do whatever will make it more useful to the committee.

It was asked if the new Meth facility being built will be paid in part by Medicaid for some of the patients.

Bob stated that it is all under Department of Corrections. It may happen in the future but not as of today.

The commission was asked if the grid was getting them somewhere that will help to clarify the purpose of the committee.

- It is becoming more helpful to put some dollar figures on services.
- It would be helpful to be able to say which ones might be similar or comparable
- The grid shows the result of the rate methodologies being used. A member is very interested in knowing what methodology was used in developing some of the other rates for some service systems. What are some of the other service community rates that don't have the national methodologies and haven't had the contracted services, how were they developed and have they been rebased. Would also like to know what department's staff believe are comparable rates across service systems and what the difference is.
- Whenever you design a rate system you are trying to achieve certain goals. The rate systems all have sets of incentives and disincentives. It would be helpful to say what the goal of the program is.

It was asked, that if we understood the history of the rates and the incentives that we were trying to impart by setting the rate in that way, how you would get a handle on that.

Gail stated that looking at areas like DDP and in other areas there is some history based on "if you build it they will come." We have to try to think about the incentives or disincentives that will come about because of that rate.

Gail stated she thought that the commission should develop a cheat sheet that they could go back to and refresh memories of how rates were set or the methodology used.

Public Comment:

Jani McCall stated that the commission is making really good headway with the grid. One recommendations made in previous meetings is that it is important to have a rate methodology category and how the rate was arrived at. The first rate matrix that was established around children's mental health started in about 1988 or 1989. At that point those levels of care where funded at about 85% of the cost of care. In the past residential treatment centers did do cost reporting but has not occurred for a long time. There has never been a formal cost reporting process for any level of care and that is one of the problems. Rates have been designed by when a group of providers or individual providers have agreed to open up their services to a new level of care. There is a task force right now that is looking at therapeutic group rates. Campus based is really the most intensive of the two levels of care that are now existing but the rate is less for campus based then for intensive base due to when the rate was set. The task force has looked at redefining the rules for these levels of care. We have recommended rules now but not enough funding to recommend those rules. A cost of care study for therapeutic group care was attempted and was able to get some information but providers were very concerned about how that study was done. There is an inconsistency all the way along. What the MCIPA would like to see is that there be some sort of consistent process to look at the cost of care equitably with some sort of formula that makes sense so that the rates can be raised to the appropriate levels. Look at a consistent cost of living increase.

It was asked if there has been any attempt to figure out which one actually works the best comparing the therapeutic and the regular group homes.

> Providers in the state are now beginning to gather that data. There has been a decrease in RTC because we have increased community based services for children.

One thing that a provider wanted conveyed to the commission is that they know it will be a long term process and it will take a while to get your hands wrapped around this and come up with a system but in the mean time we cannot let providers just sit. The gap is going to get bigger and bigger between cost of care and rates. Even though there may not be formal rate recommendations this year for the session the commission really needs to look at least some consistent cost of living increase to at least keep these providers going.

It was noted that at the last meeting the commission wanted to ask the department to consider expanding the commission to include additional technical advisors similar to the capacity of Bob Olsen because they felt like there was people with a lot more knowledge than many of the members had. A letter was drafted to Director Joan Miles asking for three additional seats on the commission and that Jim Fitzgerald and Jani McCall fill two of those and the commission would consider who would fill the third one as the commission proceeds and the kind of expertise they might need.

History of Foster Care & Group Home Rates:

<u>Dave Thorsen – CFSD Operations and Fiscal Services Bureau Chief:</u>

There were three handouts given. Dave went over the handouts giving a history of the foster care rates. Dave stated that in 1988 on an aggregate basis the department was only paying 66-67% of the actual cost of providing the care. The system was implemented

effective in January of 1989. The only real updates to that system since that time have been the legislatively authorized rate increases. There has not been a rebase of that system due to cost and time needed for that project.

Dave stated that to do a foster care rate study you need to separate out the medical cost from cost that would be considered normal foster care cost. There are two ways of doing that: one is to identify staff and cost that are directly allocable to the Medicaid program versus cost that is shared by programs. Those costs would have to be based on either a random moment time study or an actual time study within a certain time period.

Dave went over the Model Rate Matrix handout. He gave a brief overview of the Foster Care Model Rate Structure handout. One of the assumptions that went into the rates was that facilities would operate at 90% capacity. There is a lot of detail within the handout and he said that if you wanted to know that stuff it is there.

Questions and Comments:

It was asked what the difference is between a level one and a level five.

Dave stated that the different levels relate to the needs of the children.

The question of who the providers are that are being talked about.

This model rate matrix is primarily for facilities.

Is there anything in relationship as to what a family gets paid?

Dave stated that he does not have any historical information on how the original family foster care rates where developed. The current foster care rates are in the grid that Jeff handed out. There was a very significant boost in the family foster care rates in 2000 of about $1.50. The legislature has also given increases including a 4% increase for pretty much all providers except specialized and therapeutic family foster care.

It was asked if the services purchased for children's mental health in HRD use the same group homes that Dave is talking about or different. If they are using the same group homes is foster care only paying general fund or are they paying Medicaid as well.

Dave stated that foster care normally only pays from Title IV-E funding about 50% of the time. Only approximately 1% of foster care clients do not qualify for Medicaid.

How does a person compare rates between the old matrix and the new matrix?

Most foster care clients are paid for room and board out of foster care and the therapeutic portion is paid out of Medicaid. There are few rare exceptions where foster care will pay a treatment component but very seldom.

It was asked why foster care would not pay for more of the treatment component due to the ineligibility for SED of most children unless under EPSDT.

Dave stated that he was not sure at the time but he can look for that information.

It was brought up to differentiate between a regular group home, which is funded entirely from Title IV-E or from the foster care budget as opposed to a therapeutic group home which is funded through both foster care and Medicaid fund.

It was stated that it would be helpful to know the difference between the group homes when foster care uses one that is not Medicaid eligible, why it is not, what the services are, and what would escalate for a child to be placed out of a group home that is not Medicaid or therapeutic into a therapeutic group home. Why would a child be in a group home if they didn't have therapeutic needs?

James Corrigan explained the differences between the two types of homes. A regular group home originally came about. In 1987 or 89 they refinanced and they found a way to decrease the foster care budget and use Medicaid funds. What became of that is there was a treatment component that came in that could be paid through Medicaid funding. That program served the groups that were severely emotionally disturbed. Regular foster care homes still served some of those clients but essentially they were originally homes for children that were pulled out of their home or were creating problems for the local youth courts. Then the various portions of the funding were taken out to pay for the room and board for the therapeutic homes funded with Medicaid.

It was stated that when we talk about foster care we are talking about foster families and foster group homes. We cannot ignore any of these groups or any of the types of services listed under foster care.

It was asked at how much of a percentage has foster care rates went up.

Dave stated that he does not know off hand but the family foster care rates have gone up significantly more than the facility rates simply because of the infusion of $1.50 a day in 2000. It can easily be calculated for the next meeting.

Mary stated that there is a stair step process. Foster care licensing is the basis, and then as you have children that are a little more ill they have to meet the entire foster care group care of things but they also have to meet the therapeutic care things. A child can be emotionally disturbed and be in a regular group home because some needs could be met through school counselors, personal psychologist, group therapy, etc. Developmentally there are children at different levels. She stated that younger children tend to go into foster care homes where as the older children tend to go into a group care.

Dave gave some rates for comparison. In 1996 foster care rate for children 0-12 was $11.18, current rate is $15.63. For children 13-18 foster care rate was $14.09, current is $18.81. A level 3 home in 1992 was $41.44 and current it is $53.70 + 4%.

Dave stated that the division has requested for three biennium in a row for funding to do a rebasing but due to other needs it has never made it out of the department.

It was brought up that during budget times the foster care families don't get clothing allowance, travel, and other things that would be added in support. It becomes sort of difficult to look at the rate alone. We need to know how frequently or if the clothing allowance is funded. Another thing that is difficult is that if we are just looking at rates most of them are based on either national methodologies or methodologies that are very recent and current and the foster care is close to 20 years old. Would like to have, on the

cheat sheet, whether the methodologies are national based or evidence, and how recent it was.

Dave commented about the clothing allowance and other services and that there are about 230 codes that are used for paying for services. About 110 of those codes are used in any given year. With regards to the clothing, it is actually built into the regular foster care rate. The other 200 is given every six months for special needs. The other codes do have a requirement that does need to be met.

The commission was asked who they thought should be at the next meeting to help them to understand more.

Someone to explain rate development 101
More providers that have a lot of experience in providing these services
Foster parents that can answer questions
Find someone from eastern Montana
Report from the task force that was developed for rates for the therapeutic side of foster care

Wrap up:

Potentials for future meeting:

More providers from therapeutic and regular group homes
Rate development, what does it mean
Pete Surdock and his team from Task force.
Jeff Sturm about rate development
Possibly someone from Maximus
Possibly someone from NCSL or Milbank Fund
Possibly someone from the National Governors' Association
Susan Fox
Kevin Quinn from ACS
Find out what state has the best health care system in operation.
Guiding principles for systems
What the proposals for rate rebase was and how much it would cost
Find out what percentage charges should be
Meeting adjourned at 3:55 PM

Handouts:

Analysis of Select Physician Fees
State by State Comparisons Graphs
Montana's Community Health Centers Presentation
Memo from Jeff Harrison to Commission about Rate Grids
Foster Care Rate Grid
Community Based Rate Grid
Non-Community Based Rate Grid
Synopsis of Model Rate Matrix CFSD
Model Rate Matrix CFSD
Foster Care Model Rate Structure booklet